90-665 (1)

No.

IN THE

Supreme Court of the United States

OCTOBER TERM, 1990

BENEFIT TRUST LIFE INSURANCE COMPANY,
Petitioner,
vs.
DANIEL KUNIN,
Respondent.

ON PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

ROBERT F. KEEHN, *Counsel of Record*
BOOTH, MITCHEL & STRANGE
Thirtieth Floor
3435 Wilshire Boulevard
Los Angeles, California 90010-2050
(213) 738-0100

RAYMOND L. LESTER, *Of Counsel*
BENEFIT TRUST LIFE INSURANCE COMPANY
400 Field Drive
Lake Forest, Illinois 60045
(708) 615-1500

Attorneys for Petitioner
BENEFIT TRUST LIFE INSURANCE COMPANY

Lawyers Brief Service / Legal Printers / (213) 383-4457 / (714) 720-1510

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QUESTION PRESENTED

Whether, in reviewing an insurer's denial of ERISA benefits to an ERISA plan participant, a court may apply the state law rule of contract interpretation requiring that ambiguities in an insurance contract be resolved against the insurer.

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No. _____

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BENEFIT TRUST LIFE INSURANCE COMPANY,
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PETITION FOR WRIT OF CERTIORARI

The petitioner respectfully prays that a writ of certiorari issue to review a judgment and order of the United States Court of Appeals for the Ninth Circuit.[1]

OPINIONS BELOW

The original opinion rendered by the United States Court of Appeals for the Ninth Circuit was reported as *Kunin v. Benefit Trust Life Insurance Company,* 898 F.2d 1421 (9th Cir. March 21, 1990) and is attached as

[1] The parties to the proceedings before the United States Court of Appeals were those indicated by the case caption. Each of petitioner's subsidiary corporations are wholly owned. The Health Insurance Association of America and the American Council of Life Insurance appeared as *amici curiae.*

Appendix B herein. The Court of Appeals' amended opinion was reported under the same name at 910 F.2d 534 (9th Cir. July 27, 1990) and is attached as Appendix A herein. The opinion rendered by the United States District Court following trial was published under the same name at 696 F. Supp. 1342 (C.D. Calif. 1988) and is attached as Appendix D herein.

JURISDICTION

The instant petition is taken from the judgment of the United States Court of Appeals for the Ninth Circuit entered March 21, 1990. The judgment was the subject of a petition for rehearing, which was denied by an order issued in connection with the Court of Appeals' amended opinion dated July 27, 1990. Accordingly, the instant petition is timely pursuant to Rule 13.4 of the Rules of the Supreme Court of the United States.

It is submitted that jurisdiction to review the judgment in question by writ of certiorari is conferred on this Court under 28 U.S.C. §1254(1).

STATUTORY PROVISIONS

The issue presented herein concerns, generally, the standard of review applicable to actions governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001, *et seq.*, and, specifically, the degree to which a court may incorporate state common law rules of insurance contract construction into its review of a claim for ERISA plan benefits under 29 U.S.C. §1132(a)(1)(B), which provides that:

> A civil action may be brought . . . by a participant or beneficiary . . . to

> recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan [.]

STATEMENT OF THE CASE

In the Summer of 1986, Alex Kunin (hereinafter "Alex"), the dependent son of respondent Daniel Kunin (hereinafter "respondent" or "Kunin"), was admitted to the UCLA Neuropsychiatric Institute, where he remained hospitalized for approximately thirty days with a diagnosis of "organic brain dysfunction . . . and syndrome of autism secondary to the first diagnosis." For purposes of the proceedings below, the parties agreed that the diagnosis was, in relevant part, one of "autism."

The nature of autism was the subject of extensive expert testimony at trial. Petitioner does not dispute the general characterization of autism as a pervasive developmental disability affecting an afflicted child's development and functioning in various areas.

During the relevant time period, both respondent and Alex were covered under a group plan of health and medical insurance issued to respondent's employer by petitioner Benefit Trust Life Insurance Company (hereinafter "petitioner"). The subject plan contained a provision limiting benefits for the treatment of "mental illness or nervous disorders" to a maximum of $10,000 in any calendar year. The cost of Alex's treatment at the Neuropsychiatric Institute far exceeded $10,000. Following a claim by respondent, petitioner concluded that autism was a mental illness, within the language of the plan's limiting provision, and declined to pay benefits in

excess of $10,000 in connection with respondent's claim. This action ensued.

The complaint in this matter was filed in Los Angeles County Superior Court on April 28, 1987. Petitioner was served on May 12, 1987 and removed the matter to United States District Court on June 10, 1987, asserting federal question jurisdiction under 28 U.S.C. §§ 1331 and 1441 and ERISA, 29 U.S.C. §§ 1001, *et seq.* The parties subsequently stipulated to the foregoing basis for federal jurisdiction, as well as the preemptive effect of ERISA on Kunin's original state law claims for extra-contract compensatory and punitive damages.

Following a bench trial in July of 1988, judgment for respondent was entered on September 19, 1988 and is attached as Appendix E herein. Petitioner timely appealed the judgment on October 18, 1988. In an opinion issued March 21, 1990, a panel of the United States Court of Appeals for the Ninth Circuit affirmed the District Court's judgment in favor of respondent. A petition for rehearing was filed on April 4, 1990. On or about May 22, 1990, the Health Insurance Association of America and the American Council of Life Insurance moved for leave to file a brief of *amici curiae* in support of the petition for rehearing, submitting the proposed *amici* brief at the same time.

The Court of Appeals issued an amended opinion on July 27, 1990. The motion of the Health Insurance Association of America and the American Council of Life Insurance for leave to appear as *amici curiae* was granted. The petitions for rehearing filed by respondent and the *amici* were denied.

REASONS FOR GRANTING THE WRIT

A. INTRODUCTION

In *Firestone Tire & Rubber Company v. Bruch,* 489 U.S. ___, 103 L.Ed.2d 80, 109 S.Ct. 948 (1989), the Court held that a denial of ERISA plan benefits challenged by an action brought under 29 U.S.C. §1132(a)(1)(B) is subject to *de novo* review unless the governing plan document gives to the fiduciary or administrator discretion to determine eligibility for benefits or construe the terms of the plan. 103 L.Ed.2d at 95. Although the Court in *Firestone* quite plainly prescribed a degree of review much less deferential to ERISA administrators than that employed under the former "arbitrary and capricious" standard, it is equally clear that the Court did not direct reviewing courts to employ a standard under which the interpretation given ERISA plan language by *claimants* is to be deferred to. After deciding that "[i]n determining the appropriate standard of review for actions under §1132(a)(1)(B), we are guided by principles of trust law," the Court pointed out that "[a]s they do with contractual provisions, courts construe terms in trust agreements without deferring to *either* party's interpretation." 103 L.Ed.2d at 92, 93 (emphasis added).

In affirming the trial court's judgment for respondent, the Court of Appeals concluded in its original opinion that the term "mental illness," as used in the subject ERISA plan, is ambiguous, and held that California law's well-known rule requiring that ambiguities in insurance contracts be construed against the insurer (the rule of "*contra proferentem*") should be incorporated into its ERISA analysis "as a matter of federal common law." 898 F.2d at 1425-27, slip op. at 2977-82.

In their petitions for rehearing below, petitioner and the *amici* argued that the foregoing result was inconsistent with the above-cited language from *Firestone*. Accordingly, in its amended opinion, the Court of Appeals observed:

> Benefit Trust does argue, however, that *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. ___, 109 S.Ct. 948 (1989), effectively abolished the rule of *contra proferentem* for *all* ERISA plans. Benefit Trust is supported on this point by the Health Insurance Association of America and the American Council of Life Insurance, appearing as *amici curiae*. Benefit Trust and the *amici* point to the *Firestone* Court's adoption of "settled principles of trust law," which require courts to "construe terms in trust agreements without deferring to either party's interpretation." 489 U.S. at ___, 109 S.Ct. at 955. We are thus asked to conclude that trust-law principles leave no room for the rule of *contra proferentem* in ERISA cases. We decline to do so.
>
> Even if we overlook the considerable irony involved in Benefit Trust's attempt to invoke the *dicta* of *Firestone* while asking us not to apply its holding, we do not read *Firestone* as broadly as we are urged. In that case, as we explained earlier, the Supreme Court was discussing the standard according to which courts should

review a plan administrator's interpretation of plan provisions. The Court held that reviewing courts should interpret disputed provisions *de novo,* not defer to the administrator's interpretation. The Court said nothing whatsoever about the ordinary principles of construction according to which courts and administrators alike should arrive at their interpretations. Benefit Trust and the *amici* thus misread *Firestone* because they fail to distinguish between (1) using certain presumptions, including presumptions in favor of a party, in order to arrive at the correct interpretation, and (2) deferring to a particular party's interpretation. Rejecting (2) obviously does not undermine the soundness of (1). We might say, for example, that a jury should not defer to a defendant's plea of "not guilty" — we want the jury to determine his guilt or innocence *de novo.* However, this in no way implies that the jury, in making this determination, is not required to *presume* innocence — and indeed, to presume it quite strongly. Again, we might say that a baseball umpire should not defer to a baserunner's claim that he is safe; but this proposition is fully consistent with the separate rule that ties go [to] the runner. Likewise, while we may not defer to an insured's construction, we must not fail to indulge in a presumption that

> ambiguous language favors the insured.
>
> This common-sense view of the matter is supported by *Firestone* itself. The Court there noted, "The trust law *de novo* standard of review is consistent with the judicial interpretation of employee benefit plans prior to the enactment of ERISA [, when] [a]ctions challenging an employer's denial of benefits [were] governed by principles of contract law." 489 U.S. at ___, 109 S.Ct. at 955. It is, then, quite plain that the *Firestone* Court intended no wholesale rejection of prevailing principles of plan interpretation when it looked to trust law on the subject of the appropriate standard of judicial review.

910 F.2d at 540-541; slip op. at 7959-61.

B. THE WRIT SHOULD BE GRANTED BECAUSE THE COURT OF APPEALS HAS DECIDED A FEDERAL QUESTION IN A WAY THAT APPEARS TO CONFLICT WITH THE APPLICABLE DECISION OF THIS COURT

It is apparent that the *Kunin* court's amended opinion represents an attempt to harmonize its application of the *contra proferentem* rule with the earlier-quoted language of this Court in *Firestone Tire & Rubber Company v. Bruch.* Petitioner submits, however, that the Court of

Appeals' use of the state law derived rule of insurance contract interpretation nonetheless is in conflict with the applicable language in *Firestone.*

Prior to its decision in *Kunin,* the Ninth Circuit had determined that California's common law of contract interpretation is not " 'specifically directed toward [the insurance] industry,' " concluding that "California's common law of contract interpretation is not a law that 'regulates insurance,' and therefore is not saved from preemption [under ERISA]." *Kanne v. Connecticut General Life Insurance Company,* 859 F.2d 96, 100-101 (9th Cir. 1988). Other federal appellate courts have held that federal courts interpreting ERISA-governed group insurance plans must apply a uniform federal law, rather than adopting the common law of the forum state or another state. In *Arnold v. Life Insurance Company of North America,* 894 F.2d 1566, 1567 (11th Cir. 1990), the court explained that "[f]ederal common law is that law fashioned by the federal courts through their interpretation of policy language and is not based upon any calculation of the majority of decisions from other jurisdictions." Likewise, in *McMahan v. New England Mutual Life Insurance Company,* 888 F.2d 426, 429 (6th Cir. 1989), in holding Kentucky common law rules of insurance contract interpretation to be preempted by ERISA, the court specifically rejected any application of state common law to an ERISA-regulated benefit plan, remarking that "[w]e think it clear that subjecting an ERISA fiduciary to the vagaries of state contract law regarding its benefits decisions would create the very real prospect that the fiduciary's administrative scheme would be subject to conflicting requirements in the various states." As this Court explained in *Pilot Life Insurance Company v. Dedeaux,* 481 U.S. 41, 95 L.Ed.2d 39, 107 S.Ct. 1549 (1987), "[t]he expectation that a federal

common law of rights and obligations under ERISA-regulated plans would develop . . . would make little sense if the remedies available to ERISA participants and beneficiaries . . . could be supplemented or supplanted by varying state laws." 95 L.Ed.2d at 53.

To a degree, of course, the Court of Appeals' amended opinion in *Kunin* represents an effort to address the argument for the application of a uniform federal law, rather than various state laws, to ERISA-governed claims. In deciding that the rule of *contra proferentem* constituted an alternative basis for its affirmance of the trial court's decision in favor of respondent, the *Kunin* court acknowledged that "[t]here is room for disagreement as to whether a uniform federal rule of construction applies when we construe an ambiguous provision in an ERISA insurance contract or whether the applicable state law rule of construction is incorporated into federal law for that purpose." 910 F.2d at 539; slip op. at 7957 [footnote omitted]. "However," the court continued, "we need not decide that question here, because the rule of *contra proferentem* would control in either event. As we noted above, the *contra proferentem* rule is followed in all fifty states and the District of Columbia, and with good reason . . . ." *Id.* at 539-540; slip op. at 7957-58.

In this respect, then, the Court of Appeals' use of the state law derived ambiguity rule, if otherwise appropriate, was not necessarily inconsistent with the use of a uniform national rule of law. What is much more troubling and, petitioner submits, less persuasive about the amended opinion in *Kunin* is the rationale employed by the court in attempting to harmonize its result with the pertinent language in *Firestone*.

As discussed above, the amended opinion in *Kunin* drew a distinction between "(1) using certain presumptions, including presumptions in favor of a party, in

order to arrive at the correct interpretation, and (2) deferring to a particular party's interpretation," concluding that "[r]ejecting (2) obviously does not undermine the soundness of (1)." 910 F.2d at 541; slip op. at 7960.

With due respect to the *Kunin* court, petitioner submits that the foregoing distinction is one without any real difference. In the context of the *contra proferentem* doctrine, a "presumption" in favor of the insured is in practice indistinguishable from total deference to that party's interpretation of the ERISA plan's ambiguous word or phrase. Under California law, at least, an ambiguity only exists where two or more reasonable interpretations are possible. *See Gray v. Zurich Insurance Company,* 65 Cal.2d 263, 269-270, 54 Cal.Rptr. 104, 419 P.2d 168 (1966). Thus, quite unlike the presumption of innocence afforded a criminal defendant, the "presumption" that accompanies the rule of *contra proferentem* operates *conclusively* against the ERISA insurer. Such an automatic and unyielding result, petitioner submits, is inconsistent with the neutral trust law based standard of review prescribed by this Court in *Firestone.*

C. ALTERNATIVELY, THE WRIT SHOULD BE GRANTED BECAUSE THE COURT OF APPEALS HAS DECIDED AN IMPORTANT QUESTION OF FEDERAL LAW WHICH HAS NOT BEEN, BUT SHOULD BE, SETTLED BY THIS COURT

Even assuming that the Court of Appeals' use of the *contra proferentem* rule was not in direct conflict with

the *de novo* standard of review enunciated in *Firestone*, it is far from clear that this Court contemplated results such as that reached by the *Kunin* court when it prescribed the standard of review applicable to actions under 29 U.S.C. §1132(a)(1)(B).

As discussed above, the *Kunin* court concluded that its "common sense view of the matter is supported by *Firestone* itself," pointing to language in the latter case which commented upon the consistency between the trust law *de novo* standard of review and the pre-ERISA judicial interpretation of employee benefit plans, which was governed by principles of contract law. 910 F.2d at 541; slip op. at 7961. In comparing a standard of review based on trust law principles with one based on principles of contract interpretation, however, it appears very unlikely that this Court contemplated the use of the *contra proferentem* rule or similar doctrines, the application of which (in the context of a claim for ERISA plan benefits) clearly is inconsistent with a standard of review that does *not* involve deference to either party's interpretation of disputed plan language. The comparison between principles of trust law and contract law made by this Court in *Firestone* was internally consistent because contract law *in general* does not dictate that ambiguities be resolved in favor of one, and against the other, of the contracting parties. Rather, in such situations, the intent of the parties is ascertained through extrinsic evidence. Thus, it is reasonable to conclude that the *Firestone* court was not considering such *limited* rules of construction when it commented upon the similarities between standards of review based, respectively, on trust law and contract law principles.

CONCLUSION

Whether or not a court reviewing a claim for ERISA plan benefits under 29 U.S.C. §1132(a)(1)(B) may apply a state law rule of contract construction which automatically resolves ambiguities against an ERISA insurer is an important question of federal law which should be settled, or at least clarified, by this Court.

Petitioner prays that certiorari be granted.

Respectfully submitted,

BOOTH, MITCHEL & STRANGE

ROBERT F. KEEHN

Attorneys for Petitioner
Benefit Trust Life Insurance Company

APPENDIX A

FOR PUBLICATION

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

DANIEL KUNIN, *Plaintiff-Appellee,* v. BENEFIT TRUST LIFE INSURANCE COMPANY, *Defendant-Appellant.*	No. 88-6573 D.C. No. CV-87-3715-IH ORDER AND AMENDED OPINION

Appeal from the United States District Court
for the Central District of California
Hon. Irving Hill, Senior District Judge, Presiding

Argued and Submitted
November 2, 1989—Pasadena, California

Filed March 21, 1990
Amended July 27, 1990

Before: William A. Norris, Stephen Reinhardt and Stephen S. Trott, Circuit Judges.

Opinion by Judge Reinhardt

SUMMARY

ERISA/Insurance

Affirming a judgment of the district court, the court of appeals held that an ambiguous term in a group health and medical policy governed by the Employeee Retirement

Income Security Act of 1974, 29 U.S.C. § 1002(1) must be construed in favor of the insured.

The court amended its opinion filed March 21, 1990 and published at 898 F.2d 1421 (9th Cir. 1990) by deleting the last two sentences in the last introductory paragraph and substituting a new one dealing with the construction of an ambiguous term in an insurance policy. The court also deleted all of section C except the last sentence of the opinion and replaced it with an entire new section on ambiguity in the language of the policy exclusion. The court granted the motion of the Health Insurance Association of America and the American Council of Life Insurance for leave to appear as amici curiae. The petition for rehearing filed by the amici and by Benefit Trust were denied. Appellant Benefit Trust Life Insurance Company appealed the decision of the district court awarding benefits to appellee Daniel Kunin, the Senior Vice-President of Maxim's Beauty Salon, Inc. who incurred over $50,000 in medical treatment of his child for autism. Kunin sought reimbursement of his expenses under a group health insurance policy issued to his employer under ERISA. After a brief, cursory investigation by Benefit Trust's medical director, Benefit Trust agreed to pay $10,000 but no more, on the ground that autism fell within the policy's limitation for mental illness. The district court found the testimony of Kunin's experts clear, authoritative, and entirely convincing with their definition of mental illness consistent with the plain and ordinary meaning of the term.

[1] The court agreed that the denial of benefits was arbitrary and capricious. [2] The evidence that Benefit Trust's medical director gathered provided an altogether inadequate basis for determining autism to be a mental illness. The record does not indicate that the doctors with whom the medical director consulted had any significant expertise concerning autism. [3] The district court's finding that including autism within the policy's limitation clause was unreasonable is supported by the testimony of Kunin's experts.

[4] According to the law of California and every other state as well as the District of Columbia, ambiguities in insurance contracts must be construed against the insurer. This rule of contra proferentem has been called the most familiar expression in the reports of insurance cases. [5] Of course, neither the law of California nor that of any other state is applicable in this case of its own force. The group health and medical policy that covers Kunin is an employee welfare benefit plan as defined by ERISA. Section 502 of ERISA, rather than state contract law, provides the legal basis for Kunin's claim. [6] There is room for disagreement as to whether a uniform federal rule of construction applies when the court construes an ambiguous provision in an ERISA insurance contract, or whether the applicable state rule of construction is incorporated into federal law for that purpose. However, in this case, the court did not need to decide that question because the rule of contra proferentem controls in either event.

[7] It remained only for the court to determine if the meaning of the term mental illness is so clear and well fixed that an ordinary reader of the policy would recognize that autism must be included. A plain reading of the language told the court beyond any question that mental illness is ambiguous, insofar as autism is concerned. There is no definition or explanation of the term "mental illness" nor is there any illustration of the conditions that are included or excluded. The failure of the policy to define its terms is fatal to the insurer's attempt to limit payment. [8] The court held that Benefit Trust erred in failing to construe the ambiguity in favor of Kunin.

COUNSEL

Robert F. Keehn, Booth, Mitchel & Strange, Los Angeles, California, for the defendant-appellant.

Sanford M. Gage and Thomas F. Borcher, Beverly Hills, California, for the plaintiff-appellee.

ORDER

The motion of the Health Insurance Association of America and the American Council of Life Insurance for leave to appear as *amici curiae* is granted. The petitions for rehearing filed by the *amici* and by Benefit Trust are denied.

The original opinion in this case, filed March 21, 1990 (slip op. 2967) and published at 898 F.2d 1421 (9th Cir. 1990), is hereby amended as follows:

1. At the top of the second column of page 1422, in the last introductory paragraph, delete "Under California law . . . federal common law governing ERISA claims." In lieu thereof, insert the following:

> Under the law of all fifty states and the District of Columbia, where an unclear or ambiguous term is used in an insurance policy, the ambiguity must be construed in favor of the insured. We therefore hold, in the alternative, that this rule of construction applies in the case before us, whether as a uniform rule of federal common law, or because federal common law incorporates state law on this point.

2. Beginning at the bottom of the second column of page 1425, and continuing to page 1428, delete all of section C except the last sentence of the opinion. In lieu thereof, insert the following:

C. Ambiguity in the Language of the Policy Exclusion

According to the law of California[5] and, indeed,

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[5]See *State Farm Mut. Auto. Ins. Co. v. Partridge*, 10 Cal. 3d 94, 101-02, 514 P.2d 123, 109 Cal. Rptr. 811 (1973).

every other state as well as the District of Columbia,[6] ambiguities in insurance contracts must be construed against the insurer. This rule of *contra proferentem* has been called "the most familiar expression in the reports of insurance cases." 2 G. Couch *et al.*, *supra* note 6, § 15:74, at 334. A typical statement of the rule is that if, after applying the normal principles of contractual construction,

> the insurance contract is fairly susceptible of two different interpretations, another rule of construction will be applied: the interpretation that is most favorable to the insured will be adopted. The rule is based upon the principle of contract construction that when one party is responsible for the drafting of an instrument, absent evidence indicating the intention of the parties, any ambiguity will be resolved against the drafter.

A. Windt, *supra* note 6, § 6.02, at 281-82 (footnote omitted). Because we find the language of the limitation in question to be ambiguous, we hold in favor of coverage on the alternative ground that Benefit Trust, in its capacity as insurer, did not properly construe the ambiguities in its policy in Kunin's favor.

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[6]See 2 G. Couch, R. Anderson, and M. Rhodes, *Couch on Insurance 2d*, § 15:83, at 399 n.4 (rev. ed. 1984) (citing cases from the District of Columbia and 47 states, with no cases cited for a contrary position); 13 J. Appleman & J. Appleman, *Insurance Law and Practice* § 7401, at 197 n.1 (rev. ed. 1976 & Supp. 1989) (citing cases from the District of Columbia and 48 states, including the three not included in the 47 listed in Couch, with no cases cited for a contrary position). *See also* A. Windt, *Insurance Claims and Disputes* § 6.02, at 286 (2d ed. 1988) (stating that "the rule favoring coverage will be applied in all jurisdictions").

Of course, neither the law of California nor that of any other state[7] is applicable here of its own force. The group health and medical policy that covers Kunin is an "employee welfare benefit plan" as defined by ERISA, 29 U.S.C. § 1002(1); section 502 of ERISA, rather than state contract law, provides the legal basis for Kunin's claim. However, "[c]ontroversies directly affecting the operations of federal programs, although governed by federal law, do not inevitably require resort to uniform federal rules." *United States v. Kimbell Foods*, 440 U.S. 715, 727-28 (1979). State law can sometimes control such controversies, either because Congress intends courts to look to state law, or because the incorporation of state law into the federal common law is "appropriate as a matter of judicial policy under the three-part test established by *Kimbell Foods*." *Mardan Corp. v. C.G.C. Music, Ltd.*, 804 F.2d 1454, 1458 (9th Cir. 1986).

There is room for disagreement as to whether a uniform federal rule of construction applies when we construe an ambiguous provision in an ERISA insurance contract or whether the applicable state rule of construction is incorporated into federal law for that purpose.[8] However, we need not decide that

[7]In discussing the construction of insurance contracts, Benefit Trust cites only California law. However, because Maxim's is a Minnesota corporation and the plaintiff is a resident of Minnesota, we note that Minnesota law is to the same effect. *Hubred v. Control Data Corp.*, 442 N.W.2d 308 (Minn. 1989). Without deciding the question, we therefore indulge in Benefit Trust's tacit assumption that if any state's law controls, it is the law of California.

[8]Briefly stated, the controversy revolves in substantial part around the effect of ERISA's preemption provisions, which provide the most probative evidence of Congress's intention regarding choice of law under ERISA (even though this is not a preemption case). Section 514(a) provides in sweeping terms for the preemption of "any and all State laws insofar as they

question here, because the rule of *contra proferentem* would control in either event. As we noted above, the *contra proferentem* rule is followed in all fifty states and the District of Columbia, and with good reason. Insurance policies are almost always drafted

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may now or hereafter *relate to any employee benefit plan.*" 29 U.S.C. § 1144(a) (emphasis added). However, Congress also enacted an "insurance saving clause" in § 514(b)(2)(A), which states that with one exception not relevant here, "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which *regulates insurance* . . . ." 29 U.S.C. § 1144(b)(2)(A) (emphasis added). Although the breadth of § 514(a) leaves no doubt about the importance Congress attached to the federal interests involved, it seems equally clear that Congress meant to leave *some* state laws regulating insurance contracts intact — even though they may also "relate to" ERISA plans. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 746-47 (1985). However, both this court and others have had some difficulty in determining when a law "regulates insurance" for the purpose of this complex preemption analysis. *See, e.g., Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) (holding that Mississippi's cause of action for tortious breach of a covenant of good faith and fair dealing is not a law "which regulates insurance," and is thus preempted by ERISA); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 744, (1985) (holding that a state law requiring insurers to provide certain benefits "regulates insurance" and is therefore not preempted; and suggesting along the way that the interpretation *of an insurance policy* is at "the core of the 'business of insurance,' " (emphasis added) (quoting *SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969)); *Kanne v. Connecticut Gen. Life Ins. Co.*, 867 F.2d 489 (9th Cir. 1988), *cert. denied*, 109 S. Ct. 3216 (1989) (relying on *Pilot Life* and holding that "California's common law of contract interpretation" is preempted in a suit founded exclusively upon state law); *McMahan v. New England Mut. Life Ins. Co.*, 888 F.2d 426, 429-30 (6th Cir. 1989) (following *Kanne* and holding that because Kentucky's rule of *contra proferentem* is a rule of general contract law rather than a law "which regulates insurance," state decisions applying that rule do not provide an independent state-law cause of action that escapes ERISA preemption, but not considering the content of federal common law). Moreover, if we were to determine that the *Kimbell Foods* test controls, there is ample room for disagreement as to whether the application of those standards in the case before us would result in the adoption of a uniform federal rule or the incorporation of each state's law. *See Mardan Corp.*, 804 F.2d at 1458-60.

by specialists employed by the insurer. In light of the drafters' expertise and experience, the insurer should be expected to set forth any limitations on its liablility clearly enough for a common layperson to understand; if it fails to do this, it should not be allowed to take advantage of the very ambiguities that it could have prevented with greater diligence. Moreover, once the policy language has been drafted, it is not usually subject to amendment by the insured, even if he sees an ambiguity; an insurer's practice of forcing the insured to guess and hope regarding the scope of coverage requires that any doubts be resolved in favor of the party who has been placed in such a predicament. Were we to promulgate a federal rule, we would find these commonsense rationales sound. Indeed, it would take a certain degree of arrogance to controvert an opinion held with such unanimity in the various states and to adopt a contrary view as the federal rule. We hold, therefore, that the rule of *contra proferentem* applies to the case at bar, regardless of whether it applies as a matter of uniform federal law or because federal law incorporates state law on this point.

Benefit Trust points out additionally that in some instances this court has declined to apply the rule of *contra proferentem* in ERISA cases. *See, e.g., Jung v. FMC Corp.*, 755 F.2d 708, 713 (9th Cir. 1985); *Smith v. CMTA-IAM Pension Trust*, 654 F.2d 650, 655 (9th Cir. 1981); *Rehmar v. Smith*, 555 F.2d 1362, 1369 (9th Cir. 1976). As Benefit Trust concedes, however, those cases involved language that resulted from collective bargaining; Benefit Trust does not even suggest that this is such a case. Indeed, the district court found that the insurer was solely responsible for drafting the language at issue here. 696 F. Supp. at 1343.

Benefit Trust does argue, however, that *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. __, 109 S. Ct. 948 (1989), effectively abolished the rule of *contra proferentem* for *all* ERISA plans. Benefit Trust is supported on this point by the Health Insurance Association of America and the American Council of Life Insurance, appearing as *amici curiae*. Benefit Trust and the *amici* point to the *Firestone* Court's adoption of "settled principles of trust law," which require courts to "construe terms in trust agreements without deferring to either party's interpretation." 489 U.S. at __, 109 S. Ct. at 955. We are thus asked to conclude that trust-law principles leave no room for the rule of *contra proferentem* in ERISA cases. We decline to do so.

Even if we overlook the considerable irony involved in Benefit Trust's attempt to invoke the *dicta* of *Firestone* while asking us not to apply its holding, we do not read *Firestone* as broadly as we are urged. In that case, as we explained earlier, the Supreme Court was discussing the standard according to which courts should review a plan administrator's interpretation of plan provisions. The Court held that reviewing courts should interpret disputed provisions *de novo*, not defer to the administrator's interpretation. The Court said nothing whatsoever about the ordinary principles of construction according to which courts and administrators alike should arrive at their interpretations. Benefit Trust and the *amici* thus misread *Firestone* because they fail to distinguish between (1) using certain presumptions, including presumptions in favor of a party, in order to arrive at the correct interpretation, and (2) deferring to a particular party's interpretation. Rejecting (2) obviously does not undermine the soundness of (1). We might say, for example, that a jury should not defer to a defendant's plea of "not

guilty" — we want the jury to determine his guilt or innocence *de novo*. However, this in no way implies that the jury, in making this determination, is not required to *presume* innocence — and indeed, to presume it quite strongly. Again, we might say that a baseball umpire should not defer to a baserunner's claim that he is safe; but this proposition is fully consistent with the separate rule that ties go the runner. Likewise, while we may not defer to an insured's construction, we must not fail to indulge in a presumption that ambiguous language favors the insured.

This common-sense view of the matter is supported by *Firestone* itself. The Court there noted, "The trust law *de novo* standard of review is consistent with the judicial interpretation of employee benefit plans prior to the enactment of ERISA[, when] [a]ctions challenging an employer's denial of benefits [were] governed by principles of contract law." 489 U.S. at __, 109 S. Ct. at 955. It is, then, quite plain that the *Firestone* Court intended no wholesale rejection of prevailing principles of plan interpretation when it looked to trust law on the subject of the appropriate standard of judicial review.

It remains only for us to determine if the meaning of the term "mental illness" is so clear and well fixed that an ordinary reader of the policy would recognize that autism must be included. If not, in light of the rule that ambiguities in the policy must be construed against the insurer, Kunin must prevail. A plain reading of the language tells us beyond any question that "mental illness" is ambiguous, at least insofar as autism is concerned. The policy contains no definition or explanation of the term "mental illness," and offers no illustration of the conditions that are included or excluded. Nor does the policy

contain any language suggesting whether the cause or the manifestation determines whether an illness is covered; yet in the case of autism the answer to that question may well be determinative. Here, the failure of the policy to define its terms is fatal to the insurer's attempt to limit payment.

Insurance contracts generally spell out in inordinate detail the meaning of terms that lack a fixed meaning. Great efforts are ordinarily made to eliminate the natural ambiguity that exists in so many of the words and phrases we use daily. In this policy, however, Benefit Trust made no attempt whatsoever to describe the scope of a term that has no precise or generally accepted definition. Under these circumstances, we conclude that the term "mental illness" is ambiguous. The vague evidence on which Benefit Trust's medical director based his determination, and the evidence in the form of opinion testimony offered by Alex Kunin's doctors, strongly support our conclusion. Thus, we hold that Benefit Trust erred in failing to construe the ambiguity in favor of the insured.[9]

With these amendments made, the amended opinion is hereby ordered republished in its entirety.

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[9]In *Equitable Life Assurance Soc'y v. Berry,* 212 Cal. App. 3d 382, 260 Cal. Rptr. 819 (Ct. App. 1989), a California court recently ruled against a claimant in a case with some substantial similarities to the one before us. In *Equitable* the illness was manic-depression; however, the reasoning of the opinion appears to conflict in some respects with the basic view we have expressed. On the other hand the *Equitable* policy, unlike the one before us, defined "[m]ental or nervous treatment" in a manner that may well have covered the treatment involved; furthermore, the testimony of the experts in that case was of a wholly different order. In any event, we simply do not believe that the meaning of the bare, unexplained term "mental illness" is so plain and clear that the ordinary citizen would understand that *autism,* as opposed to manic-depression, is excluded from full coverage under the policy.

OPINION

REINHARDT, Circuit Judge:

Benefit Trust Life Insurance Company ("Benefit Trust") appeals the decision of the district court awarding benefits to Daniel Kunin ("Kunin"). Kunin, the Senior Vice-President of Maxim's Beauty Salons, Inc., incurred over $50,000 in medical bills for the treatment of his child for autism. Kunin sought reimbursement of his expenses under a group health insurance policy issued to his employer; the parties agree that this policy is itself an "employee welfare benefit plan" governed by ERISA, and that Benefit Trust functioned as both insurer and plan administrator. Following a brief investigation, Benefit Trust agreed to pay $10,000, but no more, on the ground that autism fell within the policy's limitation for "mental illness." The district court concluded that autism is not a mental illness and that the denial of benefits was arbitrary and capricious, and ordered that the claim be paid in full. We agree that Benefit Trust was obligated to pay the full amount of the claim.

Benefit Trust's medical director's cursory investigation did not provide reasonable grounds for determining that autism is a mental illness. The testimony of Kunin's experts amply supports the finding that Benefit Trust's denial of benefits on the basis of that inquiry was arbitrary and capricious. Moreover, it is unclear whether the term "mental illness" encompasses autism. Under the law of all fifty states and the District of Columbia, where an unclear or ambiguous term is used in an insurance policy, the ambiguity must be construed in favor of the insured. We therefore hold, in the alternative, that this rule of construction applies in the case before us, whether as a uniform rule of federal common law, or because federal common law incorporates state law on this point.

FACTS

Benefit Trust is the insurer and plan administrator of a group health and medical policy which covers Kunin by virtue of his employment status with Maxim's. The policy is an "employee welfare benefit plan" as defined by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1002(1).

In 1986 Kunin's son, Alex, received treatment for autism for approximately thirty days at the UCLA Neuropsychiatric Institute. Having incurred $54,696.96 in hospital bills as a result of his son's stay, Kunin submitted a claim to Benefit Trust.

The policy limits medical benefits for "mental illness or nervous disorders" to $10,000 per calendar year. Benefit Trust refused to pay any amount in excess of that sum because it determined that autism was a mental illness within the meaning of the policy, and was therefore subject to the policy's limiting clause. This decision was based on the recommendation of Dr. Zolot, Benefit Trust's medical director. Dr. Zolot made the determination that autism was a mental illness after having informal conversations with three psychiatrists, whose experience with autism is unknown, and after reviewing a textbook definition of autism which states that autism is generally accepted to be organically based, although it was once thought to be "primarily psychiatric."

Kunin filed suit in state court, challenging Benefit Trust's interpretation of the policy. Benefit Trust removed the matter to federal court, asserting federal question jurisdiction under ERISA. Kunin acknowledged this basis of federal jurisdiction, conceded that his state claims were preempted, and proceeded solely on the basis of his ERISA claim.

THE DISTRICT COURT OPINION

The issue put to the district court by the parties was whether Benefit Trust's denial of benefits, based on its view

that autism was a mental illness, was arbitrary and capricious. The court noted that while administrators' decisions are normally reviewed under an "arbitrary and capricious" standard, less rigorous standards have been applied when the administrator is not entirely impartial or objective, and may have a vested interest in denying benefits. It said that where the plan administrator is also the insurer, as in the present case, a lower standard of review might be appropriate. *Kunin v. Benefit Trust Life Ins. Co.*, 696 F. Supp. 1342, 1345 (C.D. Cal. 1988). However, since it concluded that the decision of Benefit Trust could be overturned even under the "arbitrary and capricious" standard, the court declined to decide whether a lower standard of review would ordinarily be applicable. *Id.*

Although insurance contract terms are interpreted as a lay person would interpret them, the district court primarily considered the testimony of experts. However, it, correctly, relied on that testimony solely in order to determine the "plain and ordinary" meaning of the term "mental illness." Kunin's expert, Dr. Betty Jo Freeman, testified that "mental illness" refers to "a behavioral disturbance with no demonstrable organic or physical basis . . . . [It] stems from reaction to environmental conditions as distinguished from organic causes." Autism clearly falls outside the scope of mental illness under this definition. Dr. Ritvo, Kunin's second expert, agreed with the definition, and testified that his experiences with families of autistic individuals have shown that the disease is not commonly perceived as a mental illness.[1] The court found the testimony of these experts "clear, authoritative, and entirely convincing," and found their definition of "mental illness" consistent with the plain and ordinary meaning of the term. *Id.* at 1346.

Benefit Trust's expert, Dr. Marvin Gillick, first offered a

[1]Dr. Ritvo has participated in the publication of over 100 papers on autism, and, we are told, is generally recognized as the world's foremost authority on the subject.

definition of "mental disorder" found in the American Psychiatric Association's *Psychiatric Glossary*. "Mental disorder" is defined as "an illness with . . . impairment in functioning due to a social, psychologic, genetic, physical/chemical, or biologic disturbance . . . . The illness is characterized by *symptoms* and/or impairment in functioning."[2]

The district court rejected Dr. Gillick's definition, noting that it could include a myriad of ailments that would never be considered mental illnesses, such as cancer or a broken leg. Dr. Gillick then suggested that mental illness was "an aberrant behavior syndrome or manifestation which has its basis in the neurological axis and/or central nervous system, but whose precise etiology is uncertain." The court rejected this definition as well, because it would exclude illnesses clearly within the ambit of mental illness solely because their causes are known. *Id.*

The court then accepted the definition offered by Kunin's experts. It held that including autism within the limitation clause covering mental illness was not a reasonable interpretation of the contract and the plan, and that the denial of benefits was arbitrary and capricious, and in violation of 29 U.S.C. § 1132. Kunin was awarded the claimed benefits plus pre-judgment interest. *Id.* at 1346-47.

ANALYSIS

A. The Standard of Review

1. *Reviewing the ERISA Administrator's Denial of Benefits*

Until recently in this circuit, denial of benefits by an ERISA administrator could ordinarily only be reversed by the district court if the decision was "arbitrary, capricious, made in

[2]Dr. Gillick is a board certified psychiatrist, but has had limited experience with autistic individuals.

bad faith, not supported by substantial evidence or erroneous as a matter of law." *Johnson v. District 2 Marine Eng'rs Beneficial Ass'n*, 857 F.2d 514, 516 (9th Cir. 1988). An administrator's opinion was said not to be arbitrary or capricious "if it [was] a reasonable interpretation of the plan's terms and was made in good faith." *Dockray v. Phelps Dodge Corp.*, 801 F.2d 1149, 1152 (9th Cir. 1986). However, when an administrator had a conflict of interest, then the district court was required to give the determination less deference than ordinarily afforded under the arbitrary and capricious standard. *Id.* In the present case, Benefit Trust has a conflict of interest, because it was the insurer as well as the administrator of the plan.

After the district court issued its opinion, the Supreme Court adopted a substantially different rule concerning the standard of review. In *Firestone Tire & Rubber Co. v. Bruch*, 109 S. Ct. 948, 956 (1989), the Court held that denial of benefits challenged under section 1132(a)(1)(B) should be reviewed *de novo* unless the plan gives the administrator the authority to exercise discretion in determining ineligibility or construing the terms of the plan. Kunin would have this court review Benefit Trust's denial of benefits under the newly announced *de novo* standard.

While acknowledging that after *Firestone* the administrator's decision would ordinarily be reviewed *de novo*, Benefit Trust contends that here it tried the case in the lower court under the "arbitrary and capricious" standard,[3] and that because of its reliance on that standard, it would be improper for us to review the case as if a different standard had been applicable. We will assume, without deciding, that Benefit

[3]Benefit Trust points to the pre-trial conference order, which states the relevant inquiry as "[w]hether the condition for which plaintiff's dependent, Alex Kunin, was examined and treated in approximately August of 1986 can be *reasonably considered* to be "mental illness or nervous disorders" (emphasis added).

Trust is correct in this regard, although we have substantial doubt that it is. Among other reasons, we see little chance that Benefit Trust was prejudiced by any reliance on the more stringent standard of review.

For purposes of this appeal, therefore, we will review the district court's decision on the assumption that it was required to determine whether Benefit Trust's denial of Kunin's claim for benefits was arbitrary and capricious. In doing so we, like the district court, will ignore Benefit Trust's conflict of interest.

2. *Reviewing the District Court's Findings*

We next consider under what standards we review the district court's determinations. The district court's finding that "mental illness," as that term is commonly understood, does not include autism was based on substantial testimony from expert witnesses as to the meaning or scope of that term. Accordingly, that finding constitutes a finding of fact, reviewed by this court under the clearly erroneous standard. *United States v. McConney,* 728 F.2d 1195, 1200 (9th Cir.), *cert. denied,* 469 U.S. 824 (1984). The conclusion that denial of coverage was arbitrary and capricious followed a full examination of the facts and circumstances underlying that determination and was essentially fact governed. Thus the mixed question of fact and law presented here, unlike most such questions, is also reviewed under the clearly erroneous standard. *Id.* at 1202. However, in this case, the question whether the term "mental illness" is ambiguous can be answered by an examination of the words of the policy alone. The district court's implied finding of ambiguity does not fall under any of the exceptions to the general rule that mixed questions of fact and law are reviewed *de novo. Id.* at 1203-04. Therefore, we review that finding under the nondeferential *de novo* standard.

B. The Medical Director's Opinion

[1] The district court found that Benefit Trust acted unreasonably in determining that autism was a "mental illness," and therefore the decision to deny benefits was arbitrary and capricious. We agree with this result.

[2] The evidence that Benefit Trust's medical director gathered provided an altogether inadequate basis for determining autism to be a mental illness. The record does not indicate that the doctors with whom the medical director consulted had any significant experience with or particular expertise concerning autism. Moreover, the director made no effort to discuss the matter with Alex Kunin's physicians, who later unequivocally testified that autism is not a mental illness. Additionally, the textbook definition Dr. Zolot relied on states that although autism was previously thought to be "primarily psychiatric, it is now thought to be organically based." On its face, this definition contains no conclusions about whether autism should be classified as a mental illness. If anything, the fact that autism is no longer considered "primarily psychiatric" suggests that autism *is not* a mental illness.

State-law cases have differed in their classification of organically based diseases like autism as mental illnesses. In *Arkansas Blue Cross & Blue Shield, Inc. v. Doe,* 22 Ark. App. 89, 733 S.W.2d 429 (1987) (en banc), the Court of Appeals of Arkansas found that classifying bipolar affective disorder (formerly manic-depressive disorder) by cause rather than by symptom was proper. Because its cause was physical (organic), the disorder was held to be not subject to the policy's mental illness limitations.

Alternatively, in *Equitable Life Assurance Society v. Berry,* 212 Cal. App. 3d 832, 260 Cal. Rptr. 819 (1989), a California court of appeals held that medical expenses incurred for the treatment of manic-depressive illness were not covered by an

insurance policy that excluded coverage for "mental or nervous disorders." Equitable's expert testified that most serious psychiatric problems, including manic-depression, are caused by physiological disease processes. The witness further testified that the only problems that would fall into the "functional" category (what Drs. Freeman and Ritvo characterize as "environmentally induced") would be marital disorders, substance abuse, and other problems caused by "the complications of our industrial society." 260 Cal. Rptr. at 824. In *Equitable,* the court held that *manifestation, not cause,* provides the "yardstick" by which one determines whether a mental disorder occurs. It therefore rejected the organic/functional distinction as a basis of determining coverage.

[3] We conclude that Dr. Zolot's inadequate investigation did not provide a reasonable basis for making a determination that autism is a mental illness.[4] This result is amply supported by the weight of the evidence adduced at trial. Drs. Ritvo and Freeman testified that mental illness "refers to a behavioral disturbance with no demonstrable organic or physical basis .... [It] stems from reaction to environmental conditions as distinguished from organic causes. Thus ... autism would clearly fall outside the aforesaid criteria and factors for mental illness." 696 F.Supp. at 1346. The district court agreed with this analysis. It noted autism's prevalence throughout the world and that its incidence and characteristics remain constant across socio-cultural environments. Moreover, it noted that autism cannot be treated by traditional methods of psychotherapy. *Id.* at 1347. The court's observations are wholly consistent with the conclusion of Drs. Ritvo and Freeman that autism is not a mental illness, in either the lay or the technical sense. The doctors' testimony, in turn, supports the district court's finding that the

[4]The administrator's decision predated *Equitable* by more than two years. Therefore, Dr. Zolot could not have relied on that case in reaching his conclusion.

defendant's inclusion of autism within the policy's limitation clause was unreasonable. We therefore conclude that the district court's holding that the denial of benefits was arbitrary and capricious was not clearly erroneous.

C. Ambiguity in the Language of the Policy Exclusion

[4] According to the law of California[5] and, indeed, every other state as well as the District of Columbia,[6] ambiguities in insurance contracts must be construed against the insurer. This rule of *contra proferentem* has been called "the most familiar expression in the reports of insurance cases." 2 G. Couch *et al., supra* note 6, § 15:74, at 334. A typical statement of the rule is that if, after applying the normal principles of contractual construction,

> the insurance contract is fairly susceptible of two different interpretations, another rule of construction will be applied: the interpretation that is most favorable to the insured will be adopted. The rule is based upon the principle of contract construction that when one party is responsible for the drafting of an instrument, absent evidence indicating the intention of the parties, any ambiguity will be resolved against the drafter.

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[5]See *State Farm Mut. Auto. Ins. Co. v. Partridge,* 10 Cal. 3d 94, 101-02, 514 P.2d 123, 109 Cal. Rptr. 811 (1973).

[6]See 2 G. Couch, R. Anderson, and M. Rhodes, *Couch on Insurance 2d,* § 15:83, at 399 n.4 (rev. ed. 1984) (citing cases from the District of Columbia and 47 states, with no cases cited for a contrary position); 13 J. Appleman & J. Appleman, *Insurance Law and Practice* § 7401, at 197 n.1 (rev. ed. 1976 & Supp. 1989) (citing cases from the District of Columbia and 48 states, including the three not included in the 47 listed in Couch, with no cases cited for a contrary position). *See also* A. Windt, *Insurance Claims and Disputes* § 6.02, at 286 (2d ed. 1988) (stating that "the rule favoring coverage will be applied in all jurisdictions").

A. Windt, *supra* note 6, § 6.02, at 281-82 (footnote omitted). Because we find the language of the limitation in question to be ambiguous, we hold in favor of coverage on the alternative ground that Benefit Trust, in its capacity as insurer, did not properly construe the ambiguities in its policy in Kunin's favor.

[5] Of course, neither the law of California nor that of any other state[7] is applicable here of its own force. The group health and medical policy that covers Kunin is an "employee welfare benefit plan" as defined by ERISA, 29 U.S.C. § 1002(1); section 502 of ERISA, rather than state contract law, provides the legal basis for Kunin's claim. However, "[c]ontroversies directly affecting the operations of federal programs, although governed by federal law, do not inevitably require resort to uniform federal rules." *United States v. Kimbell Foods,* 440 U.S. 715, 727-28 (1979). State law can sometimes control such controversies, either because Congress intends courts to look to state law, or because the incorporation of state law into the federal common law is "appropriate as a matter of judicial policy under the three-part test established by *Kimbell Foods.*" *Mardan Corp. v. C.G.C. Music, Ltd.,* 804 F.2d 1454, 1458 (9th Cir. 1986).

[6] There is room for disagreement as to whether a uniform federal rule of construction applies when we construe an ambiguous provision in an ERISA insurance contract or whether the applicable state rule of construction is incorporated into federal law for that purpose.[8] However, we need

[7]In discussing the construction of insurance contracts, Benefit Trust cites only California law. However, because Maxim's is a Minnesota corporation and the plaintiff is a resident of Minnesota, we note that Minnesota law is to the same effect. *Hubred v. Control Data Corp.,* 442 N.W.2d 308 (Minn. 1989). Without deciding the question, we therefore indulge in Benefit Trust's tacit assumption that if any state's law controls, it is the law of California.

[8]Briefly stated, the controversy revolves in substantial part around the effect of ERISA's preemption provisions, which provide the most probative

not decide that question here, because the rule of *contra proferentem* would control in either event. As we noted above, the *contra proferentem* rule is followed in all fifty states and the District of Columbia, and with good reason. Insur-

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evidence of Congress's intention regarding choice of law under ERISA (even though this is not a preemption case). Section 514(a) provides in sweeping terms for the preemption of "any and all State laws insofar as they may now or hereafter *relate to any employee benefit plan.*" 29 U.S.C. § 1144(a) (emphasis added). However, Congress also enacted an "insurance saving clause" in § 514(b)(2)(A), which states that with one exception not relevant here, "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which *regulates insurance* . . . ." 29 U.S.C. § 1144(b)(2)(A) (emphasis added). Although the breadth of § 514(a) leaves no doubt about the importance Congress attached to the federal interests involved, it seems equally clear that Congress meant to leave *some* state laws regulating insurance contracts intact — even though they may also "relate to" ERISA plans. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 746-47 (1985). However, both this court and others have had some difficulty in determining when a law "regulates insurance" for the purpose of this complex preemption analysis. *See, e.g., Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) (holding that Mississippi's cause of action for tortious breach of a covenant of good faith and fair dealing is not a law "which regulates insurance," and is thus preempted by ERISA); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 744, (1985) (holding that a state law requiring insurers to provide certain benefits "regulates insurance" and is therefore not preempted; and suggesting along the way that the interpretation *of an insurance policy* is at "the core of the 'business of insurance,' " (emphasis added) (quoting *SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969)); *Kanne v. Connecticut Gen. Life Ins. Co.*, 867 F.2d 489 (9th Cir. 1988), *cert. denied*, 109 S. Ct. 3216 (1989) (relying on *Pilot Life* and holding that "California's common law of contract interpretation" is preempted in a suit founded exclusively upon state law); *McMahan v. New England Mut. Life Ins. Co.*, 888 F.2d 426, 429-30 (6th Cir. 1989) (following *Kanne* and holding that because Kentucky's rule of *contra proferentem* is a rule of general contract law rather than a law "which regulates insurance," state decisions applying that rule do not provide an independent state-law cause of action that escapes ERISA preemption, but not considering the content of federal common law). Moreover, if we were to determine that the *Kimbell Foods* test controls, there is ample room for disagreement as to whether the application of those standards in the case before us would result in the adoption of a uniform federal rule or the incorporation of each state's law. *See Mardan Corp.*, 804 F.2d at 1458-60.

ance policies are almost always drafted by specialists employed by the insurer. In light of the drafters' expertise and experience, the insurer should be expected to set forth any limitations on its liablility clearly enough for a common layperson to understand; if it fails to do this, it should not be allowed to take advantage of the very ambiguities that it could have prevented with greater diligence. Moreover, once the policy language has been drafted, it is not usually subject to amendment by the insured, even if he sees an ambiguity; an insurer's practice of forcing the insured to guess and hope regarding the scope of coverage requires that any doubts be resolved in favor of the party who has been placed in such a predicament. Were we to promulgate a federal rule, we would find these common-sense rationales sound. Indeed, it would take a certain degree of arrogance to controvert an opinion held with such unanimity in the various states and to adopt a contrary view as the federal rule. We hold, therefore, that the rule of *contra proferentem* applies to the case at bar, regardless of whether it applies as a matter of uniform federal law or because federal law incorporates state law on this point.

Benefit Trust points out additionally that in some instances this court has declined to apply the rule of *contra proferentem* in ERISA cases. *See, e.g., Jung v. FMC Corp.*, 755 F.2d 708, 713 (9th Cir. 1985); *Smith v. CMTA-IAM Pension Trust*, 654 F.2d 650, 655 (9th Cir. 1981); *Rehmar v. Smith*, 555 F.2d 1362, 1369 (9th Cir. 1976). As Benefit Trust concedes, however, those cases involved language that resulted from collective bargaining; Benefit Trust does not even suggest that this is such a case. Indeed, the district court found that the insurer was solely responsible for drafting the language at issue here. 696 F. Supp. at 1343.

Benefit Trust does argue, however, that *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. _, 109 S. Ct. 948 (1989), effectively abolished the rule of *contra proferentem* for *all* ERISA plans. Benefit Trust is supported on this point by the Health

Insurance Association of America and the American Council of Life Insurance, appearing as *amici curiae*. Benefit Trust and the *amici* point to the *Firestone* Court's adoption of "settled principles of trust law," which require courts to "construe terms in trust agreements without deferring to either party's interpretation." 489 U.S. at __, 109 S. Ct. at 955. We are thus asked to conclude that trust-law principles leave no room for the rule of *contra proferentem* in ERISA cases. We decline to do so.

Even if we overlook the considerable irony involved in Benefit Trust's attempt to invoke the *dicta* of *Firestone* while asking us not to apply its holding, we do not read *Firestone* as broadly as we are urged. In that case, as we explained earlier, the Supreme Court was discussing the standard according to which courts should review a plan administrator's interpretation of plan provisions. The Court held that reviewing courts should interpret disputed provisions *de novo*, not defer to the administrator's interpretation. The Court said nothing whatsoever about the ordinary principles of construction according to which courts and administrators alike should arrive at their interpretations. Benefit Trust and the *amici* thus misread *Firestone* because they fail to distinguish between (1) using certain presumptions, including presumptions in favor of a party, in order to arrive at the correct interpretation, and (2) deferring to a particular party's interpretation. Rejecting (2) obviously does not undermine the soundness of (1). We might say, for example, that a jury should not defer to a defendant's plea of "not guilty" — we want the jury to determine his guilt or innocence *de novo*. However, this in no way implies that the jury, in making this determination, is not required to *presume* innocence — and indeed, to presume it quite strongly. Again, we might say that a baseball umpire should not defer to a baserunner's claim that he is safe; but this proposition is fully consistent with the separate rule that ties go the runner. Likewise, while we may not defer to an insured's construction, we must not fail to indulge in a presumption that ambiguous language favors the insured.

This common-sense view of the matter is supported by *Firestone* itself. The Court there noted, "The trust law *de novo* standard of review is consistent with the judicial interpretation of employee benefit plans prior to the enactment of ERISA[, when] [a]ctions challenging an employer's denial of benefits [were] governed by principles of contract law." 489 U.S. at _, 109 S. Ct. at 955. It is, then, quite plain that the *Firestone* Court intended no wholesale rejection of prevailing principles of plan interpretation when it looked to trust law on the subject of the appropriate standard of judicial review.

[7] It remains only for us to determine if the meaning of the term "mental illness" is so clear and well fixed that an ordinary reader of the policy would recognize that autism must be included. If not, in light of the rule that ambiguities in the policy must be construed against the insurer, Kunin must prevail. A plain reading of the language tells us beyond any question that "mental illness" is ambiguous, at least insofar as autism is concerned. The policy contains no definition or explanation of the term "mental illness," and offers no illustration of the conditions that are included or excluded. Nor does the policy contain any language suggesting whether the cause or the manifestation determines whether an illness is covered; yet in the case of autism the answer to that question may well be determinative. Here, the failure of the policy to define its terms is fatal to the insurer's attempt to limit payment.

[8] Insurance contracts generally spell out in inordinate detail the meaning of terms that lack a fixed meaning. Great efforts are ordinarily made to eliminate the natural ambiguity that exists in so many of the words and phrases we use daily. In this policy, however, Benefit Trust made no attempt whatsoever to describe the scope of a term that has no precise or generally accepted definition. Under these circumstances, we conclude that the term "mental illness" is ambiguous. The vague evidence on which Benefit Trust's medical director based his determination, and the evidence in the form of

opinion testimony offered by Alex Kunin's doctors, strongly support our conclusion. Thus, we hold that Benefit Trust erred in failing to construe the ambiguity in favor of the insured.[9]

For the two alternative reasons discussed above, the decision of the district court is

AFFIRMED.

[9]In *Equitable Life Assurance Soc'y v. Berry,* 212 Cal. App. 3d 382, 260 Cal. Rptr. 819 (Ct. App. 1989), a California court recently ruled against a claimant in a case with some substantial similarities to the one before us. In *Equitable* the illness was manic-depression; however, the reasoning of the opinion appears to conflict in some respects with the basic view we have expressed. On the other hand the *Equitable* policy, unlike the one before us, defined "[m]ental or nervous treatment" in a manner that may well have covered the treatment involved; furthermore, the testimony of the experts in that case was of a wholly different order. In any event, we simply do not believe that the meaning of the bare, unexplained term "mental illness" is so plain and clear that the ordinary citizen would understand that *autism,* as opposed to manic-depression, is excluded from full coverage under the policy.

APPENDIX B

FOR PUBLICATION

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

DANIEL KUNIN, *Plaintiff-Appellee,* v. BENEFIT TRUST LIFE INSURANCE COMPANY, *Defendant-Appellant.*	No. 88-6573 D.C. No. CV-87-3715-IH OPINION

Appeal from the United States District Court
for the Central District of California
Hon. Irving Hill, Senior District Judge, Presiding

Argued and Submitted
November 2, 1989—Pasadena, California

Filed March 21, 1990

Before: William A. Norris, Stephen Reinhardt and Stephen S. Trott, Circuit Judges.

Opinion by Judge Reinhardt

SUMMARY

ERISA/Insurance

Affirming a judgment of the district court, the court of appeals held that the California rule regarding ambiguities in insurance contracts is applicable to a group health and medical policy governed by the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002(1).

Appellant Benefit Trust Life Insurance Company appealed the decision of the district court awarding benefits to appellee Daniel Kunin, the Senior Vice-President of Maxim's Beauty Salon, Inc. who incurred over $50,000 in medical bills for the treatment of his child for autism. Kunin sought reimbursement of his expenses under a group health insurance policy issued to his employer. The parties agreed that this policy is itself an employee welfare benefit plan governed by ERISA and that Benefit Trust functioned as both insurer and plan administrator. After a brief, cursory investigation by Benefit Trust's medical director, Benefit Trust agreed to pay $10,000 but no more, on the ground that autism fell within the policy's limitation for mental illness. The district court found the testimony of Kunin's experts clear, authoritative, and entirely convincing and their definition of mental illness consistent with the plain and ordinary meaning of the term.

[1] The court agreed that the denial of benefits was arbitrary and capricious. [2] The evidence that Benefit Trust's medical director gathered provided an altogether inadequate basis for determining autism to be a mental illness. The record does not indicate that the doctors with whom the medical director consulted had any significant or particular expertise concerning autism. [3] The district court's finding that including autism within the policy's limitation clause was unreasonable is supported by the testimony of Kunin's experts.

[4] California insurance law requires that ambiguities in insurance contracts be construed against the insurer, but [5] California law is not applicable here of its own force since the group health and medical policy that covers Kunin is governed by ERISA. [6] By nature, federal programs require controlling federal rules. However, controversies directly affecting the operations of federal programs, although governed by federal law, do not inevitably require resort to uniform federal rules. [7] The court determined that the California rule regarding construction of insurance contracts applied in this case , both as a matter of congressional intent

and as a matter of sound judicial policy. Although § 514(a) of ERISA provides for the preemption of any and all state laws relating to ERISA plans, Congress also enacted an insurance savings clause stating that nothing in this subchapter shall be construed to exempt any person from any state law which regulates insurance. [8] Also, the settled expectations of all parties would be needlessly complicated if the court were to introduce a uniform federal rule of construction for policies purchased by ERISA plans, while continuing to apply a state-law rule, possibly different, to all other insurance contracts.

[9] A plain reading of the language of the policy convinced the court that the term "mental illness" is ambiguous, at least as far as autism is concerned. The failure of the policy to define its terms is fatal to the insurer's attempt to limit payment.

COUNSEL

Robert F. Keehn, Booth, Mitchel & Strange, Los Angeles, California, for the defendant-appellant.

Sanford M. Gage and Thomas F. Borcher, Beverly Hills, California, for the plaintiff-appellee.

OPINION

REINHARDT, Circuit Judge:

Benefit Trust Life Insurance Company ("Benefit Trust") appeals the decision of the district court awarding benefits to Daniel Kunin ("Kunin"). Kunin, the Senior Vice-President of Maxim's Beauty Salons, Inc., incurred over $50,000 in medical bills for the treatment of his child for autism. Kunin sought reimbursement of his expenses under a group health

insurance policy issued to his employer; the parties agree that this policy is itself an "employee welfare benefit plan" governed by ERISA, and that Benefit Trust functioned as both insurer and plan administrator. Following a brief investigation, Benefit Trust agreed to pay $10,000, but no more, on the ground that autism fell within the policy's limitation for "mental illness." The district court concluded that autism is not a mental illness and that the denial of benefits was arbitrary and capricious, and ordered that the claim be paid in full. We agree that Benefit Trust was obligated to pay the full amount of the claim.

Benefit Trust's medical director's cursory investigation did not provide reasonable grounds for determining that autism is a mental illness. The testimony of Kunin's experts amply supports the finding that Benefit Trust's denial of benefits on the basis of that inquiry was arbitrary and capricious. Moreover, it is unclear whether the term "mental illness" encompasses autism. Under California law, where an unclear or ambiguous term is used in an insurance policy, the ambiguity must be construed in favor of the insured. Because state rules regarding the construction of insurance contracts are expressly saved from ERISA preemption, and because sound judicial policy requires the application of such state rules in ERISA cases, we hold that they are incorporated into the federal common law governing ERISA claims. We affirm.

FACTS

Benefit Trust is the insurer and plan administrator of a group health and medical policy which covers Kunin by virtue of his employment status with Maxim's. The policy is an "employee welfare benefit plan" as defined by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1002(1).

In 1986 Kunin's son, Alex, received treatment for autism for approximately thirty days at the UCLA Neuropsychiatric

Institute. Having incurred $54,696.96 in hospital bills as a result of his son's stay, Kunin submitted a claim to Benefit Trust.

The policy limits medical benefits for "mental illness or nervous disorders" to $10,000 per calendar year. Benefit Trust refused to pay any amount in excess of that sum because it determined that autism was a mental illness within the meaning of the policy, and was therefore subject to the policy's limiting clause. This decision was based on the recommendation of Dr. Zolot, Benefit Trust's medical director. Dr. Zolot made the determination that autism was a mental illness after having informal conversations with three psychiatrists, whose experience with autism is unknown, and after reviewing a textbook definition of autism which states that autism is generally accepted to be organically based, although it was once thought to be "primarily psychiatric."

Kunin filed suit in state court, challenging Benefit Trust's interpretation of the policy. Benefit Trust removed the matter to federal court, asserting federal question jurisdiction under ERISA. Kunin acknowledged this basis of federal jurisdiction, conceded that his state claims were preempted, and proceeded solely on the basis of his ERISA claim.

THE DISTRICT COURT OPINION

The issue put to the district court by the parties was whether Benefit Trust's denial of benefits, based on its view that autism was a mental illness, was arbitrary and capricious. The court noted that while administrators' decisions are normally reviewed under an "arbitrary and capricious" standard, less rigorous standards have been applied when the administrator is not entirely impartial or objective, and may have a vested interest in denying benefits. It said that where the plan administrator is also the insurer, as in the present case, a lower standard of review might be appropriate. *Kunin v. Benefit Trust Life Ins. Co.*, 696 F. Supp. 1342, 1345 (C.D. Cal.

1988). However, since it concluded that the decision of Benefit Trust could be overturned even under the "arbitrary and capricious" standard, the court declined to decide whether a lower standard of review would ordinarily be applicable. *Id.*

Although insurance contract terms are interpreted as a lay person would interpret them, the district court primarily considered the testimony of experts. However, it, correctly, relied on that testimony solely in order to determine the "plain and ordinary" meaning of the term "mental illness." Kunin's expert, Dr. Betty Jo Freeman, testified that "mental illness" refers to "a behavioral disturbance with no demonstrable organic or physical basis . . . . [It] stems from reaction to environmental conditions as distinguished from organic causes." Autism clearly falls outside the scope of mental illness under this definition. Dr. Ritvo, Kunin's second expert, agreed with the definition, and testified that his experiences with families of autistic individuals have shown that the disease is not commonly perceived as a mental illness.[1] The court found the testimony of these experts "clear, authoritative, and entirely convincing," and found their definition of "mental illness" consistent with the plain and ordinary meaning of the term. *Id.* at 1346.

Benefit Trust's expert, Dr. Marvin Gillick, first offered a definition of "mental disorder" found in the American Psychiatric Association's *Psychiatric Glossary*. "Mental disorder" is defined as "an illness with . . . impairment in functioning due to a social, psychologic, genetic, physical/chemical, or biologic disturbance . . . . The illness is characterized by *symptoms* and/or impairment in functioning."[2]

[1]Dr. Ritvo has participated in the publication of over 100 papers on autism, and, we are told, is generally recognized as the world's foremost authority on the subject.

[2]Dr. Gillick is a board certified psychiatrist, but has had limited experience with autistic individuals.

The district court rejected Dr. Gillick's definition, noting that it could include a myriad of ailments that would never be considered mental illnesses, such as cancer or a broken leg. Dr. Gillick then suggested that mental illness was "an aberrant behavior syndrome or manifestation which has its basis in the neurological axis and/or central nervous system, but whose precise etiology is uncertain." The court rejected this definition as well, because it would exclude illnesses clearly within the ambit of mental illness solely because their causes are known. *Id.*

The court then accepted the definition offered by Kunin's experts. It held that including autism within the limitation clause covering mental illness was not a reasonable interpretation of the contract and the plan, and that the denial of benefits was arbitrary and capricious, and in violation of 29 U.S.C. § 1132. Kunin was awarded the claimed benefits plus pre-judgment interest. *Id.* at 1346-47.

ANALYSIS

A. The Standard of Review

1. *Reviewing the ERISA Administrator's Denial of Benefits*

Until recently in this circuit, denial of benefits by an ERISA administrator could ordinarily only be reversed by the district court if the decision was "arbitrary, capricious, made in bad faith, not supported by substantial evidence or erroneous as a matter of law." *Johnson v. District 2 Marine Eng'rs Beneficial Ass'n,* 857 F.2d 514, 516 (9th Cir. 1988). An administrator's opinion was said not to be arbitrary or capricious "if it [was] a reasonable interpretation of the plan's terms and was made in good faith." *Dockray v. Phelps Dodge Corp.,* 801 F.2d 1149, 1152 (9th Cir. 1986). However, when an administrator had a conflict of interest, then the district court was required to give the determination less deference than ordinarily afforded under the arbitrary and capricious standard. *Id.* In

the present case, Benefit Trust has a conflict of interest, because it was the insurer as well as the administrator of the plan.

After the district court issued its opinion, the Supreme Court adopted a substantially different rule concerning the standard of review. In *Firestone Tire & Rubber Co. v. Bruch*, 109 S. Ct. 948, 956 (1989), the Court held that denial of benefits challenged under section 1132(a)(1)(B) should be reviewed *de novo* unless the plan gives the administrator the authority to exercise discretion in determining ineligibility or construing the terms of the plan. Kunin would have this court review Benefit Trust's denial of benefits under the newly announced *de novo* standard.

While acknowledging that after *Firestone* the administrator's decision would ordinarily be reviewed *de novo*, Benefit Trust contends that here it tried the case in the lower court under the "arbitrary and capricious" standard,[3] and that because of its reliance on that standard, it would be improper for us to review the case as if a different standard had been applicable. We will assume, without deciding, that Benefit Trust is correct in this regard, although we have substantial doubt that it is. Among other reasons, we see little chance that Benefit Trust was prejudiced by any reliance on the more stringent standard of review.

For purposes of this appeal, therefore, we will review the district court's decision on the assumption that it was required to determine whether Benefit Trust's denial of Kunin's claim for benefits was arbitrary and capricious. In doing so we, like the district court, will ignore Benefit Trust's conflict of interest.

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[3]Benefit Trust points to the pre-trial conference order, which states the relevant inquiry as "[w]hether the condition for which plaintiff's dependent, Alex Kunin, was examined and treated in approximately August of 1986 can be *reasonably considered* to be "mental illness or nervous disorders" (emphasis added).

2. *Reviewing the District Court's Findings*

We next consider under what standards we review the district court's determinations. The district court's finding that "mental illness," as that term is commonly understood, does not include autism was based on substantial testimony from expert witnesses as to the meaning or scope of that term. Accordingly, that finding constitutes a finding of fact, reviewed by this court under the clearly erroneous standard. *United States v. McConney,* 728 F.2d 1195, 1200 (9th Cir.), *cert. denied,* 469 U.S. 824 (1984). The conclusion that denial of coverage was arbitrary and capricious followed a full examination of the facts and circumstances underlying that determination and was essentially fact governed. Thus the mixed question of fact and law presented here, unlike most such questions, is also reviewed under the clearly erroneous standard. *Id.* at 1202. However, in this case, the question whether the term "mental illness" is ambiguous can be answered by an examination of the words of the policy alone. The district court's implied finding of ambiguity does not fall under any of the exceptions to the general rule that mixed questions of fact and law are reviewed *de novo. Id.* at 1203-04. Therefore, we review that finding under the nondeferential *de novo* standard.

B. The Medical Director's Opinion

[1] The district court found that Benefit Trust acted unreasonably in determining that autism was a "mental illness," and therefore the decision to deny benefits was arbitrary and capricious. We agree with this result.

[2] The evidence that Benefit Trust's medical director gathered provided an altogether inadequate basis for determining autism to be a mental illness. The record does not indicate that the doctors with whom the medical director consulted had any significant experience with or particular expertise concerning autism. Moreover, the director made no effort to

discuss the matter with Alex Kunin's physicians, who later unequivocally testified that autism is not a mental illness. Additionally, the textbook definition Dr. Zolot relied on states that although autism was previously thought to be "primarily psychiatric, it is now thought to be organically based." On its face, this definition contains no conclusions about whether autism should be classified as a mental illness. If anything, the fact that autism is no longer considered "primarily psychiatric" suggests that autism *is not* a mental illness.

State-law cases have differed in their classification of organically based diseases like autism as mental illnesses. In *Arkansas Blue Cross & Blue Shield, Inc. v. Doe,* 22 Ark. App. 89, 733 S.W.2d 429 (1987) (en banc), the Court of Appeals of Arkansas found that classifying bipolar affective disorder (formerly manic-depressive disorder) by cause rather than by symptom was proper. Because its cause was physical (organic), the disorder was held to be not subject to the policy's mental illness limitations.

Alternatively, in *Equitable Life Assurance Society v. Berry,* 212 Cal. App. 3d 832, 260 Cal. Rptr. 819 (1989), a California court of appeals held that medical expenses incurred for the treatment of manic-depressive illness were not covered by an insurance policy that excluded coverage for "mental or nervous disorders." Equitable's expert testified that most serious psychiatric problems, including manic-depression, are caused by physiological disease processes. The witness further testified that the only problems that would fall into the "functional" category (what Drs. Freeman and Ritvo characterize as "environmentally induced") would be marital disorders, substance abuse, and other problems caused by "the complications of our industrial society." 260 Cal. Rptr. at 824. In *Equitable,* the court held that *manifestation, not cause,* provides the "yardstick" by which one determines whether a mental disorder occurs. It therefore rejected the

organic/functional distinction as a basis of determining coverage.

[3] We conclude that Dr. Zolot's inadequate investigation did not provide a reasonable basis for making a determination that autism is a mental illness.[4] This result is amply supported by the weight of the evidence adduced at trial. Drs. Ritvo and Freeman testified that mental illness "refers to a behavioral disturbance with no demonstrable organic or physical basis .... [It] stems from reaction to environmental conditions as distinguished from organic causes. Thus ... autism would clearly fall outside the aforesaid criteria and factors for mental illness." 696 F.Supp. at 1346. The district court agreed with this analysis. It noted autism's prevalence throughout the world and that its incidence and characteristics remain constant across socio-cultural environments. Moreover, it noted that autism cannot be treated by traditional methods of psychotherapy. *Id.* at 1347. The court's observations are wholly consistent with the conclusion of Drs. Ritvo and Freeman that autism is not a mental illness, in either the lay or the technical sense. The doctors' testimony, in turn, supports the district court's finding that the defendant's inclusion of autism within the policy's limitation clause was unreasonable. We therefore conclude that the district court's holding that the denial of benefits was arbitrary and capricious was not clearly erroneous.

C. Ambiguity in the Language of the Policy Exclusion

[4] California insurance law requires that ambiguities in insurance contracts be construed against the insurer.[5] Cover-

[4]The administrator's decision predated *Equitable* by more than two years. Therefore, Dr. Zolot could not have relied on that case in reaching his conclusion.

[5]In discussing the construction of insurance contracts, Benefit Trust cites only California law. However, because Maxim's is a Minnesota corporation and the plaintiff is a resident of Minnesota, we note that Minnesota law is to the same effect. *Hubred v. Control Data Corp.*, 442 N.W.2d 308 (Minn. 1989).

age clauses are interpreted broadly in favor of coverage, while exclusions are interpreted narrowly. *See State Farm Mut. Auto. Ins. Co. v. Partridge,* 10 Cal. 3d 94, 101-02, 514 P.2d 123, 109 Cal. Rptr. 811 (1973). A limitation of coverage to a specified amount is similar in purpose and effect to an exclusion and the same principles of construction should be applied to both. Because we find the language of the limitation in question to be ambiguous, we hold in favor of coverage on the alternative ground that Benefit Trust, in its capacity as insurer, did not properly construe the ambiguities in its policy in Kunin's favor, as California law requires.

[5] Of course, California law is not applicable here of its own force. The group health and medical policy that covers Kunin is an "employee welfare benefit plan" as defined by ERISA, 29 U.S.C. § 1002(1); section 502 of ERISA, rather than state contract law, provides the legal basis for Kunin's claim. Thus, the resolution of that claim implicates federal interests in an area where Congress has legislated extensively, and the rule of decision must be a federal one. However, in specifying that rule we must decide whether a uniform federal common-law rule of decision should be applied, or whether state law may be incorporated, in whole or in part, into the federal common law.

[6] By nature, federal programs require controlling federal rules. However, "[c]ontroversies directly affecting the operations of federal programs, although governed by federal law, do not inevitably require resort to uniform federal rules." *United States v. Kimbell Foods,* 440 U.S. 715, 727-28 (1979). State law can sometimes control such controversies, either because Congress intends courts to look to state law, or because the incorporation of state law into the federal common law is "appropriate as a matter of judicial policy under the three-part test established by *Kimbell Foods.*" *Mardan Corp. v. C.G.C. Music, Ltd.,* 804 F.2d 1454, 1458 (9th Cir. 1986).

[7] We believe the California rule regarding construction of insurance contracts applies here, both as a matter of congressional intent and as a matter of sound judicial policy. The clearest indication of Congress's intention regarding choice of law under ERISA is the preemption provision contained in that act.[6] Section 514(a) provides in sweeping terms for the preemption of "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). However, Congress also enacted an "insurance savings clause" in section 514(b)(2)(A), which states that with one exception not relevant here,[7] "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance . . . ." 29 U.S.C. § 1144(b)(2)(A). Although the breadth of section 514(a) leaves no doubt about the importance Congress attached to the federal interests involved, we think it equally clear that Congress meant to leave state laws regulating insurance contracts perfectly intact, and to incorporate those laws into the regulatory scheme insofar as they affect insurance contracts purchased by ERISA plans. Since this case presents us with just such a circumstance, we hold that the California rule of construction applies to the insurance contract before us as a matter of federal common law.

Even if Congress's intent to preserve state insurance law

[6]Because Kunin's suit arises under federal rather than state law, the case does not actually present a federal preemption question and we look at preemption under ERISA only as evidence of congressional intent.

[7]The exception is section 514(b)(2)(B), the so-called "deemer clause," which provides, "Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company . . . for purposes of any law of any State puporting to regulate insurance companies [or] insurance contracts . . . ." 29 U.S.C. § 1144 (b)(2)(B). This provision prevents states from evading the preemptive effect of section 514(a) by legislatively bringing self-insured plans within the scope of state law generally applicable only to insurers. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985). It is irrelevant here, however, because Benefit Trust has not been *deemed to be* an insurer; it *is* an insurer.

were less clear, we would, under *Kimbell Foods,* decline to develop a uniform federal rule to supplant California's rule of construction.[8] Under the *Kimbell Foods* test, a court must determine "(1) whether the issue requires 'a nationally uniform body of law'; (2) 'whether application of state law would frustrate specific objectives of the federal programs'; and (3) whether 'application of a federal rule would disrupt commercial relationships predicated on state law.' " *Mardan,* 804 F 2d at 1458 (quoting *Kimbell Foods,* 440 U.S. at 728-29). Applying this test to the facts before us, we conclude again that the California rule is appropriate.

[8] First, nothing about the construction of insurance contracts, even those sold to ERISA plans, calls for national uniformity. Issuers of insurance contracts have always been forced to comply with the separate and sometimes divergent constructions placed upon the language of their policies in each state, and there is no reason to believe that insurance companies are any less able to protect their interests merely because the contract in question is issued to an ERISA plan. Second, application of the state rule of construction is not, in this case, inconsistent in any way with the objectives of ERISA, because the rule of construction has no effect on the coverage for which Benefit Trust or any other insurer can contract *so long as the policy is precisely drafted.* Finally, application of a uniform federal rule of construction, applicable only to insurance contracts that "relate to any employee benefit plan," 29 U.S.C. § 1144(a), could have some adverse effect on commercial relationships predicated on the rules of construction applicable within each state to all other insurance contracts. Insureds to some extent, and members of the insurance bar to a far greater extent, rely upon settled rules of construc-

[8]See note 5 *supra.* While preemption is not, strictly speaking, at issue in this case, we note that our conclusion that the California rule of construction falls within the insurance savings clause of ERISA makes it unnecessary to decide whether it would ever be appropriate to incorporate into federal common law a state-law rule that Congress had chosen to preempt.

tion within each state in drafting, purchasing, and litigating over the meaning of insurance contracts. The settled expectations of all parties would be needlessly complicated if we were to introduce a uniform federal rule of construction for policies purchased by ERISA plans, while continuing to apply a state-law rule, possibly different, to all other insurance contracts. Among other things, such a regulatory scheme might leave insurers subject to conflicting constructions of identical language in identical policies. In short, statewide uniformity for all insurance contracts is more important than nationwide uniformity for only some of them. Thus, either as a matter of congressional intent, or as a matter of sound judicial policy, it is the state rule of construction that we must apply.

[9] It remains for us to determine if the meaning of the term "mental illness" is so clear and well fixed that an ordinary reader of the policy would recognize that autism must be included. If not, in light of the California rule that ambiguities in the policy must be construed against the insurer, Kunin must prevail. A plain reading of the language tells us beyond any question that "mental illness" is ambiguous, at least insofar as autism is concerned. The policy contains no definition or explanation of the term "mental illness," and offers no illustration of the conditions that are included or excluded. Nor does the policy contain any language suggesting whether the cause or the manifestation determines whether an illness is covered; yet in the case of autism the answer to that question may well be determinative. Here, the failure of the policy to define its terms is fatal to the insurer's attempt to limit payment.

Insurance contracts generally spell out in inordinate detail the meaning of terms that lack a fixed meaning. Great efforts are ordinarily made to eliminate the natural ambiguity that exists in so many of the words and phrases we use daily. In this policy, however, Benefit Trust makes no attempt whatsoever to describe the scope of a term that has no precise or generally accepted definition. Under these circumstances, we

conclude that the term "mental illness" is ambiguous. The vague evidence on which Benefit Trust's medical director based his determination, and the evidence in the form of opinion testimony offered by Alex Kunin's doctors, strongly support our conclusion. Thus, we hold that Benefit Trust erred in failing to construe the ambiguity in favor of the insured.[9]

For the two alternative reasons discussed above, the decision of the district court is

AFFIRMED.

[9]We recognize that one California court has recently reached a contrary result, *Equitable Life Assurance Soc'y v. Berry*, 212 Cal. App. 3d 382, 260 Cal. Rptr. 819 (Ct. App. 1989). While the illness there was manic-depression, the reasoning of the opinion appears to conflict in some respects with the view we have expressed above. On the other hand the Equitable policy, unlike the one before us, defined "[m]ental or nervous treatment" in a manner that may well have covered the treatment involved; furthermore, the testimony of the experts in that case was of a wholly different order. In any event, we do not believe that the California Supreme Court would find the meaning of the bare, unexplained term "mental illness" so plain and clear that the ordinary citizen would understand that autism is excluded from full coverage under the policy.

APPENDIX C

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

DANIEL KUNIN,
Plaintiff-Appellee,

vs.

BENEFIT TRUST LIFE
INSURANCE COMPANY,
Defendant-Apellant.

No. 88-6573
DC #CV-87-3715-IH

APPEAL from the United States District Court for the Central District of California.

THIS CAUSE came on to be heard on the Transcript of the Record from the United States District Court for the Central District of California and was duly submitted.

ON CONSIDERATION WHEREOF, It is now here ordered and adjudged by this Court, that the judgment of the said District Court in this Cause be, and hereby is AFFIRMED

Filed and entered
March 21, 1990

APPENDIX D

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

DANIEL KUNIN,
Plaintiff,
v.
BENEFIT TRUST LIFE
INSURANCE COMPANY,
Defendant.

NO. CV 87-3715-IH
OPINION

In this opinion the Court, in an apparent case of first impression, decides that autism is not a "mental illness" within the meaning of an exclusionary clause in a group health and medical insurance policy.

FACTS

Jurisdiction of the Court is invoked under ERISA (29 U.S.C. § 1132). In 1986, plaintiff Daniel Kunin was covered under a group health and medical insurance policy issued to his employer by the defendant Benefit Trust Life Insurance Company. The parties agree that

the policy itself is an "employee welfare benefit plan" under 29 U.S.C. § 1002(1). Defendant insurance company is both the writer of the policy and the administrator of the plan.

During 1986 plaintiff's dependent son, Alex Kunin, was hospitalized for about 30 days at the UCLA Neuropsychiatric Institute. Alex was diagnosed there as suffering from "organic brain dysfunction . . . and syndrome of autism secondary to the first diagnosis." That diagnosis is not disputed. Both sides characterize the diagnosis as one of autism.[1] The plaintiff incurred bills for this hospitalization and treatment in the amount of $54,696.96 and submitted a claim to the defendant in that amount.

The defendant's policy contains a limitation which limits medical benefits for "mental illness or nervous disorders" to a maximum of $10,000 in any calendar year. Defendant rejected the portion of the claim over $10,000, relying exclusively on the assertion that autism is a "mental illness" within the meaning of the policy.[2] Pursuant to this position defendant paid only $10,000 of plaintiff's claim and refused to pay the remainder. This action followed.[3] Plaintiff invokes the remedy provided

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[1] In accordance with undisputed expert testimony in the case, thoughout [*sic*] this opinion the terms "syndrome of autism" and "autism" are used as synonyms. Autism is termed a "syndrome" because it is defined solely by its symptoms, i.e., its behavioral manifestations.

[2] Defendant abjured any reliance on the "nervous disorders" portion of the policy limitation. Undisputed expert testimony at the trial established that the term "nervous disorder" is quite archaic and has no ascertainable meaning in modern usage.

[3] This action was originally brought in the Superior Court of Los Angeles County, alleging several California statutory and common law causes of action, and was removed to this Court by defendant. Following removal, the parties stipulated that the group insurance

(continued)

for in 29 U.S.C. § 1132(a)(1)(B), and seeks to recover $44,696.96, the unpaid portion of his expenses, plus attorneys fees.

The action was tried as a court trial. This opinion is meant to constitute the Court's findings of fact and conclusions of law as well as a full statement of the Court's reasoning. The case appears to be one of first impression. No prior reported opinion has been cited to the Court, and the Court has found none, which construes an identical policy limitation clause or defines the term "mental illness" in a similar context.[4]

Much of the trial concerned itself with expert testimony as to the definition and description of autism and its etiology. That testimony establishes the facts set forth below.

The syndrome of autism falls within the category of pervasive developmental disorders. The syndrome is defined by its symptoms. The essential features are a lack of responsiveness to other people, gross impairment in communicative skills, and bizarre responses to various aspects of the environment (e.g. resistance to change or peculiar interest in or attachments to certain objects). These symptoms usually appear within the first 30

(ftn. continued)
policy in issue is an "employee welfare benefit plan" under ERISA. The parties also stipulated that this action was brought solely under ERISA, 29 U.S.C. § 1132, and that all state law causes of action were preempted.

[4] One somewhat similar holding exists. In *Arkansas Blue Cross & Blue Shield v. Doe*, 733 S.W. F.2d 429 (Ark. App. 1987), an intermediate appellate court held that bipolar affective disorder is a physical illness within the coverage section of an insurance policy and is not a "mental, psychiatric or nervous condition" within a limitation provision of the policy. The case did not involve ERISA. However, the holding seems in accord with this Court's present holding since it emphasizes physical causation of that illness and its origin within the brain.

months of life. In the medical community autism is generally treated by child psychiatrists.

Two definitions of autism appear in publications of the American Psychiatric Association. The shorter, more concise definition is contained in its *Psychiatric Glossary* (1984). Autism is defined there as follows:

> "A *developmental disability* caused by a physical disorder of the brain appearing during the first three years of life. Symptoms include disturbances in physical, social, and language skills; abnormal responses to sensations; and abnormal ways of relating to people, objects and events." *Id.* at 11 (italics in original).

A much longer and more involved definition is contained in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders III* (1980). That multi-page definition is largely a description of the symptoms.

The expert testimony established that the two definitions are consistent with each other and are consistent with the Court's description of the illness *supra*.

Although the precise etiology of autism remains unknown, medical research has produced increasingly strong evidence of a demonstrable organic basis for the syndrome. Specifically, significant physical changes and dysfunctions which accompany autism have been identified within the brain. Experts in the field consider the syndrome of autism to be the behavioral expression of these underlying organic dysfunctions. This current understanding of the syndrome explains the dual diagnosis of Alex Kunin's illness at UCLA — i.e., "organic brain dysfunction" and autism "secondary" thereto. Where the physical cause of a medical condition is

known, the behavioral symptoms are viewed as "secondary" to the physical cause.

Research into the causes of autism has also led to the conclusion that the syndrome is not environmentally or psychologically based. There is a consensus among experts that the syndrome of autism is not caused by environmental trauma or childhood relationships with parents or others. It is clear that autism cannot be treated by traditional psychotherapy.

MERITS

The Court, at the threshold, must consider the proper standard of judicial review applicable to the instant case. Under the rules generally applied by appellate courts, a plaintiff seeking reversal of a decision of an ERISA plan administrator concerning entitlement to benefits must bear a substantial burden. Such a plaintiff must establish that the decision to deny benefits was arbitrary and capricious, or made in bad faith, or not supported by substantial evidence, or erroneous as a matter of law. That standard of review has been most recently enunciated by the Ninth Circuit in *Johnson v. District 2 Marine Engineers Beneficial Association,* ___ F.2d ___ Slip.Op. No. 87-1805 (9th Cir. Sept. 8, 1988). In the instant case, recognizing that he may have to meet the *Johnson* standard, plaintiff has asserted alternatively that the administrator's decision as to his claim was arbitrary and capricious and/or made in bad faith.

The *Johnson* opinion refines somewhat the "arbitrary and capricious" concept. It holds that "a decision is not arbitrary or capricious if it is based on a reasonable interpretation of the plan's terms and was made in good faith". ___ F.2d at ___, Slip.Op. at 11039. That is plaintiff's approach, as well, in this case. Though he has phrased his claim as a claim of arbitrariness and

capriciousness, he asserts simply that defendant's interpretation of the policy was not a reasonable one.

It seems to the Court that there are strong public policy considerations in the instant case which would dictate a burden of proof requirement for the plaintiff less rigorous than the *Johnson* standard. The normal situation is one in which the plan has been formulated by negotiations between labor and management and is administered under a system in which both sides are represented in the administration or in the choice of an administrator. In that type of situation, care is taken to insure that the plan administrator is impartial, objective, and has no fiscal stake in any of his interpretations or other actions. *Johnson* was just such a case. The plan there was jointly administered by a board of trustees composed of multiple employer and union representatives.

There are a few cases which have applied a lesser standard and lesser requirement of proof in situations where the plan administrator is not entirely impartial or objective and may have a vested interest in denying benefits. The Ninth Circuit has held that less deference should be afforded to the decisions of a plan administrator who is also a senior management official of the employer than is given to the decisions of an independent administrator, where the decision involves an outlay of funds by the employer. *Dockray v. Phelps Dodge Corp.*, 801 F.2d 1149, 1152 (9th Cir. 1986); *Jung v. FMC Corp.*, 755 F.2d 708, 711-712 (9th Cir. 1985.)

It would seem that the *Dockray* and *Jung* rationale is also applicable to the instant situation where the administrator, though not a management employee, is the insurer itself. The administrator here faces the same kind of conflict of fiscal interest which motivated the Ninth Circuit in *Dockray* and *Jung* to weaken the normal deference rule.

In the instant case not only does the administrator have a profit motive, a benefit to itself, in denying a claim, it is also an insurance company interpreting a standard insurance policy which it wrote and issued in return for a premium. It could be argued with some force that rather than requiring a showing of "arbitrary and capricious" conduct or lack of good faith, reversal of the administrator's decision, in a situation like this, should be allowed under standards akin to those employed in other litigation between an insurer and an insured. Those standards are well known and well established, i.e., any ambiguity or uncertainty in the policy will be construed against the insurer in order to achieve the object of coverage for the losses to which the policy relates. 1 Witkin *Summary of California Law,* 9th Ed. 632, Contracts § 639. Along the same line, the law is settled that language of coverage in a policy will be construed in the most inclusive sense for the benefit of the insured and language of exclusion will be reciprocally be [*sic*] construed in the most restrictive sense. *Reserve Ins. Co. v. Pisciotta,* 30 Cal.3d 800, 808, 180 Cal.Rptr. 628, 632 (1982).

This Court finds it unnecessary, however, to decide whether a different standard of review should be applied under the special circumstances of this case. The Court reaches its result in the instant case, one favorable to the plaintiff, by applying the *Johnson* standard for ERISA cases.

Turning to the question at bar, one preliminary question must be addressed. The words in issue in this case, "mental illness", can conceivably be characterized as a scientific or technical term. The Court must therefore decide whether the words should be given an exclusively scientific or technical definition (i.e., a definition that would be employed by the scientific and technical

community which deals with the field of inquiry) as opposed to a "lay" definition.

The Court has determined to reject a scientific or technical definition. One cannot ignore the fact that the words in question were used in an insurance policy which was written by non-scientists, approved by non-scientist insurance commissioners, and purchased by lay persons for the protection of lay persons.

It has been long-established that insurance policy language and terms should be construed in accordance with the plain and ordinary meaning that a lay person would ordinarily attach to them rather than in their technical sense. 2 *Couch on Insurance* §15:17 (2d. ed. 1984); *Franceschi v. American Motorists Insurance Co.*, ___ F.2d ___, Slip Op. No. 87-6014 (9th Cir. July 29, 1988). In this Court's view, the policy term in question here should also be given the plain and ordinary meaning that a lay person would ordinarily attach to it.

Before offering any definition for the words "mental illness", plaintiff contended that the Court should determine that the term is a meaningless one, and therefore the Court should strike the limitation clause and disregard it entirely. In support plaintiff offered expert testimony that "mental illness" is a term that has no precise meaning among medical and research experts, and would not be used by professionals in the field to precisely delineate *any* category of medical conditions. Despite this evidence, it seems to the Court that the term can be given a plain and ordinary meaning, sufficient as generally applied by lay persons, to distinguish particular medical conditions from others. In other words, the term is susceptible of a lay definition despite its lack of an accepted precise technical meaning. Plaintiff's request to strike the limitation clause as meaningless is thus rejected.

Each side proposed different definitions of the term "mental illness" as used by lay persons. Plaintiff's expert witnesses, Drs. Edward Ritvo and Betty Jo Freeman,[5] testified that "mental illness" refers to a behavioral disturbance with no demonstrable organic or physical basis. Along the same line, they testified that a mental illness stems from reaction to environmental conditions as distinguished from organic causes. Thus, plaintiff's experts concluded, autism would clearly fall outside the aforesaid criteria and factors for mental illness. Both of plaintiff's expert witnesses were clear, authoritative and entirely convincing in their testimony.

Defendant's expert witness, Dr. Marvin Gillick[6] suggested two different definitions of mental illness. One was the definition of a different term, "mental disorder" as found in the American Psychiatric Association's *Psychiatric Glossary*.[7] That definition was:

> "an illness with . . . impairment in functioning due to a social, psychologic, genetic, physical/chemical,

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[5] Both are professors at the UCLA School of Medicine. Their research and clinical practices have focused on autism for many years. Each has published extensively in the field. Dr. Ritvo has authored, along or with others, over 100 papers on autism in professional journals and texts. He is generally recognized as the world's foremost authority on autism, its etiology and its treatment.

[6] Dr. Gillick is a Clinical Associate Professor of Psychiatry at the USC School of Medicine. He has had minimal clinical experience with autism and has done no research in the field. He did not claim to be an expert on autism.

[7] The glossary did not specifically define "mental illness". Instead, the mental illness entry merely instructed the reader to "see mental disorder" without stating whether the two terms were viewed as synonyms.

> or biologic disturbance. . . . The illness is characterized by *symptoms* and/or impairment in functioning." *Id.* at 89 (italics in original).

The *Psychiatric Glossary* definition could include almost every imaginable physical disorder including cancer, glaucoma or a broken leg. It would include many conditions which no lay person would ever remotely consider to be mental illnesses. The glossary definition cannot be viewed as a serious or intelligible effort to differentiate mental illness from other types of medical conditions.[8] The Court rejects it as unreasonable on its face.

Dr. Gillick's second proposed definition was "an aberrant behavior syndrome or manifestation which has its basis in the neurological axis and/or central nervous system, but whose precise etiology is uncertain." (Gillick, *Depo.* at 21) This definition, with its emphasis on the *precise etiology* being unknown, must also be rejected. If the general nature of the cause of an illness is known and the cause is organic, the illness should not be encompassed within the term "mental illness" merely because of a lack of precision in the understanding of its causation.

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[8] In an attempt to buttress its claim that the glossary definition of mental disorder should be adopted by the Court as its definition of mental illness, defendant pointed to the fact that autism is listed in the *Diagnostic and Statistical Manual of Mental Disorders III* at 87-90. That publication is clearly intended to provide diagnostic categories for use by medical professionals. Its use for other purposes would not be justified. As the *Manual* itself says, "the use of this manual for nonclinical purposes, such as determination of legal responsibility . . . or justification for third-party payment, must be critically examined in each instance within the appropriate institutional context." *Id.* at 12.

The Court finds that the definition offered by plaintiff corresponds to the general lay understanding of the term "mental illness", especially in conjunction with other factors emphasized by plaintiff's experts.

As the evidence indicates, mental illness is often thought of by lay persons as having nonphysical, psychological causes, in the Freudian sense, as opposed to an organic basis. Where dysfunctions of the brain derive from an identifiable organic basis, as in the case of brain cancer or Alzheimer's disease, the condition would not commonly be understood as mental illness. A related factor which can distinguish mental illnesses is their causation by environmental factors, such as traumatic experiences or childhood relationships. Autism exists throughout the world. It is not caused by environmental factors and it is unaffected by manipulation of environments. Its incidence and characteristics remain constant across socio-cultural environments.

Another important factor tending to place autism outside the ambit of "mental illnesses" is the nature of its treatment. Autism cannot be treated with any of the traditional methods of psychotherapy.[9] Such treatability and methods of treatment, i.e., psychotherapy, are certainly the methods which would be primarily associated, in the minds of the lay public, with the problem of "mental illness".

To summarize, the Court concludes that defendant's inclusion of autism within the limitation clause covering "mental illness" was not a reasonable interpretation of the contract and the plan. As a result, defendant has arbitrarily and capriciously denied plaintiff's claim for

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[9] There is no cure for autism. At present, the treatment consists of a combination of medication, to control the physical problem to a limited extent, and special education to help the patients make use of their strengths and function around their weaknesses.

benefits in violation of 29 U.S.C. § 1132, and is liable to plaintiff for those unpaid benefits plus prejudgment interest.

If, *arguendo,* it is held that the term "mental illness" must be given a scientific or technical meaning, the Court would reach the same result. Plaintiff's experts testified persuasively that they and their colleagues would not use the term "mental illness" in connection with developmental disorders such as autism, and that professionals in that field would not generally consider autism a mental illness. Autism would more appropriately be referred to by scientific professionals as a disease or disorder of the brain. Thus it would be unreasonable to classify autism as a mental illness even giving that term an exclusively scientific or technical meaning.

ATTORNEYS FEES

In an action to recover benefits due under an ERISA plan, attorneys fees may be awarded at the Court's discretion. 29 U.S.C. § 1132(g)(1). The factors to be considered in exercising this discretion were enumerated in *Hummell v. S.E. Rykoff & Company,* 634 F.2d 446, 453 (9th Cir. 1980), as follows:

> "(1) the degree of the opposing parties' culpability or bad faith; (2) the ability of the opposing parties to satisfy an award of fees; (3) whether an award of fees against the opposing parties would deter others from acting under similar circumstances; (4) whether the parties requesting fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant

> legal question regarding ERISA; and (5) the relative merits of the parties' positions."

With regard to factors (1) and (5), the Court finds that defendant did not act in bad faith, and the relative merits did not tilt overwhelmingly in plaintiff's favor. The listing of autism in various books relating to psychiatry and mental disorders could lead one to a superficial conclusion that autism was a mental illness. There were no additional indicia of bad faith behavior on the part of defendant. Factor (4), seeking to benefit all beneficiaries, is inapplicable to this action. As to factor (3), only a minimal deterrent effect would be achieved by a fee award in this case, and in light of the absence of bad faith, this factor is not sufficient to justify a fee award. Having considered the relevant guidelines, the Court declines to exercise its discretion to award fees in this case.

A separate judgment will be entered in accordance with this opinion.

DATED: SEPTEMBER 19, 1988.

/s/ Irving Hill
IRVING HILL, Judge
United States District Court

APPENDIX E

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

DANIEL KUNIN,
Plaintiff,

v.

BENEFIT TRUST LIFE INSURANCE COMPANY,
Defendant.

NO. CV 87-3715-IH
JUDGMENT

The within action came before the Court for trial July 15, 1988. Trial continued through and including July 20, 1988. Appearances were: For plaintiff, Gage, Mazursky, Schwartz, etc. by Richard H. Rabkin, Esq., and for defendant, Booth, Mitchel & Strange by Robert Keehn, Esq.

The Court announced on July 20, 1988 that judgment in the action would be for plaintiff and that an opinion would follow.

Pursuant to an opinion of the Court filed this day, which constitutes the Court's findings of fact and conclusions of law as well as a statement of its reasons, IT IS ORDERED, ADJUDGED AND DECREED AS FOLLOWS:

1. Plaintiff DANIEL KUNIN shall have judgment against defendant BENEFIT TRUST LIFE INSURANCE CO. in the amount of $44,696.96 plus prejudgment interest as hereinafter set forth, plus costs of $_____.

By agreement of the parties, evidenced by a letter filed September 9, 1988, prejudgment interest runs from October 22, 1986 to the date of the filing of this judgment and is computed at the rate of 7.54%. The amount of prejudgment interest to and including September 19, 1988, the date of the filing of this judgment is $6,435.60. Thus the total judgment granted herein with prejudgment interest included to date is $51,132.56.

2. Plaintiff's request for an award of attorneys fees is denied.

3. The Clerk shall transmit by U.S. mail a copy of this judgment to all counsel of record.

DATED: September 19, 1988.

/s/ Irving Hill
IRVING HILL, Judge
United States District Court

Taxed costs in sum of $ 1777.40 , against DEFENDANTS